Disclaimer

PETERSEN® INTERNATIONAL UNDERWRITERS

Insurance can be effective only after the underwriting department receives and reviews your application. The earliest effective date will be the next day after the review.

Underwriting department is open from Monday through Friday, 7 AM to 4 PM, Pacific Time, excluding holidays.

By submitting this paper application, you acknowledge and agree that:

- Back dated applications are not possible.
- Requested effective date is not always guaranteed.
- It does not matter when you send the application by postal mail, fax or scanned copy in email.
- It does not matter when the postal mail, fax or email was received by us, as the underwriting department can consider the effective date only according to when they review the application.
- If there is any dispute between you and the underwriting department about when the effective date should be, the decision of the underwriting department will be final.
- You hold Insubuy and the writing agent (if any) harmless and relieve us from any liability because of this.

If the above terms are not acceptable to you, please do not submit the application.

If you need to purchase the insurance urgently with a specific effective date, please call our office at +1 (866) INSUBUY or the writing agent to confirm, before sending the application.

Insubuy®, Inc. 4200 Mapleshade Ln, Suite 200, Plano, TX 75093 | Phone: +1 (866) INSUBUY | Fax: (972) 767-4470 | info[at]insubuy.com

PETERSEN® INTERNATIONAL UNDERWRITERS

Producer #: 25735

Application For High Limit Accidental Death Insurance

Proposed Insured: First _____ Middle _____ Last _____

Personal Statistics: Date of Birth ____/____/____ Height _____ Weight _____ Gender ○Male ○Female

Contact Information: Email _____ Telephone (____)____-____ Fax (____)____-____

Residence Address: Number & Street _____

City _____ State_____ Zip Code _____

Occupation: _____ Employer:_____

Business Address: Number & Street _____

City _____ State_____ Zip Code _____

Annual Income: US$ _____ Net Worth: US$_____

Requested Sum Insured: US$_____

Period of Insurance: Requested Effective Date _____ Expiry Date _____

Beneficiary: _____ Relationship _____

Address: _____

Policy Owner (If not the insured): _____ Relationship _____

Address: _____

_____

Benefits (Check one): ☐ **24 Hour**

Coverage (Check one): ○ **Accidental Death (AD)** **or** ○ **Accidental Death & Dismemberment (AD&D)**

The following questions are to be answered by the proposed insured. If "Yes" is answered for any of the following questions please provide full details in the space below.

1. Do you have any physical defect or infirmity? ○Yes ○No
2. Is your sight or hearing defective? ○Yes ○No
3. Have you suffered from, been diagnosed with, received treatment for, or been prescribed treatment for any condition related to any nervous or mental condition, fainting episode, blackout, fit or paralysis of any kind? ○Yes ○No
4. Have you suffered from, been diagnosed with, received treatment for, or been prescribed treatment for high blood pressure, a heart condition, rheumatic fever or diabetes? ○Yes ○No
5. Have you suffered from, been diagnosed with, received treatment for, or been prescribed treatment for a "slipped disc" or other spinal disorder, a hernia or any rheumatic or arthritic condition? ○Yes ○No
6. Have you ever been declined or accepted on special terms for life, accident or illness insurance? ○Yes ○No
7. Do you intend to engage in hazardous sports or any other pastimes that expose you to extra personal injury? ○Yes ○No
8. Will you be travelling outside of the USA? ○Yes ○No
9. Will any of your air travel be on private or chartered aircraft? ○Yes ○No
10. Is there anything preventing you from working full-time in your occupation? ○Yes ○No

Question #	Please provide detailed information for each question answered "Yes"

DECLARATION I declare that the above statements are true and complete, and that, apart from the matters declared above, I am in good health and ordinarily enjoy good health. I agree to the Underwriters obtaining medical information from any doctor who has attended me and authorize such doctor to give this information. I agree that this proposal shall form the basis of the contract should the insurance be effected and any misstatements above may be grounds for recision. I understand that pre-existing conditions are not covered until a period of insurance of 12 months, treatment free, has elapsed.

Proposed Insured _____ Signature _____ Date_____

Policy Owner Signature (If other than the proposed Insured) _____ Date_____